§457.740 State expenditures and statistical reports.

(a) *Required quarterly reports.* A State must submit reports to CMS that contain quarterly program expenditures and statistical data no later than 30 days after the end of each quarter of the Federal fiscal year. A State must collect required data beginning on the date of implementation of the approved State plan. Territories are exempt from the definition of ''State'' for purposes of the required quarterly reporting under this section. The quarterly reports must include data on—

(1) Program expenditures;

(2) The number of children enrolled in the title XIX Medicaid program, the separate child health program, and the Medicaid expansion program, as applicable, as of the last day of each quarter of the Federal fiscal year; and

(3) The number of children under 19 years of age who are enrolled in the title XIX Medicaid program, the separate child health program, and in the Medicaid expansion program, as appropriate, by the following categories:

(i) Age (under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age).

(ii) Gender, race, and ethnicity.

(iii) Service delivery system (managed care, fee-for-service, and primary care case management).

(iv) Household income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) *Reportable household income categories.* (1) A State that does not impose cost sharing or a State that imposes cost sharing based on a fixed percentage of income must report by two household income categories:

(i) At or below 150 percent of FPL.

(ii) Over 150 percent of FPL.

(2) A State that imposes a different level or percentage of cost sharing at different poverty levels must report by poverty level categories that match the poverty level categories used for purposes of cost sharing.

(c) *Required unduplicated counts.* Thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for the Federal fiscal year of children who were enrolled in the Medicaid program, the separate child health program, and the Medicaid expansion program, as appropriate, by age, gender, race, ethnicity, service delivery system, and poverty level categories described in paragraphs (a) and (b) of this section.

§457.750 Annual report.

(a) *Report required for each Federal fiscal year.* A State must report to CMS by January 1 following the end of each Federal fiscal year, on the results of the State's assessment of the operation of the State plan.

(b) *Contents of annual report.* In the annual report required under paragraph (a) of this section, a State must—

(1) Describe the State's progress in reducing the number of uncovered, low-income children and; in meeting other strategic objectives and performance goals identified in the State plan; and provide information related to a core set of national performance goals and measures as developed by the Secretary;

(2) Report on the effectiveness of the State's policies for discouraging the substitution of public coverage for private coverage;

(3) Identify successes and barriers in State plan design and implementation, and the approaches the State is considering to overcome these barriers;

(4) Describe the State's progress in addressing any specific issues (such as outreach) that the State plan proposed to periodically monitor and assess;

(5) Provide an updated budget for a 3-year period that describes those elements required in §457.140, including any changes in the sources of the non-Federal share of State plan expenditures;

(6) Identify the total State expenditures for family coverage and total number of children and adults, respectively, covered by family coverage during the preceding Federal fiscal year;

(7) Describe the State's current income standards and methodologies for its Medicaid expansion program, separate child health program, and title XIX Medicaid program, as appropriate.

(c) *Methodology for estimate of number of uninsured, low-income children.* (1) To report on the progress made in reducing the number of uninsured, low-income children as required in paragraph

(b) of this section, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children who are uninsured in the State.

(i) A State may base the estimate on data from—

(A) The March supplement to the Current Population Survey (CPS);

(B) A State-specific survey;

(C) A statistically adjusted CPS; or

(D) Another appropriate source.

(ii) If the State does not base the estimate on data from the March supplement to the CPS, the State must submit a description of the methodology used to develop the initial baseline estimate and the rationale for its use.

(2) The State must provide an annual estimate of changes in the number of uninsured in the State using—

(i) The same methodology used in establishing the initial baseline; or

(ii) Another methodology based on new information that enables the State to establish a new baseline.

(3) If a new methodology is used, the State must also provide annual estimates based on either the March supplement to the CPS or the methodology used to develop the initial baseline.

[66 FR 2683, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

Subpart H—Substitution of Coverage

SOURCE: 66 FR 2684, Jan. 11, 2001, unless otherwise noted.

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) *Scope.* This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

EFFECTIVE DATE NOTE: At 78 FR 42313, July 15, 2013, § 457.805 was revised, effective . For the convenience of the user, the revised text is set forth as follows:

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

(a) *State plan requirements.* The state plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

(b) *Limitations.* (1) A state may not, under this section, impose a period of uninsurance which exceeds 90 days from the date a child otherwise eligible for CHIP is disenrolled from coverage under a group health plan.

(2) A waiting period may not be applied to a child following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program.

(3) If a state elects to impose a period of uninsurance following the loss of coverage under a group health plan under this section, such period may not be imposed in the case of any child if:

(i) The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;

(ii) The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v).

(iii) The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

(iv) The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;

(v) A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);

(vi) The child has special health care needs; and